### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2009

					Inspection	JUIC		
Part I	Part I Annual Report Identification Information							
For cale	ndar plan year 2009 or fiscal p	olan year beginning 01/01/2009		and ending 12/31/2	2009			
A This	return/report is for:	a multiemployer plan;	a multip	ole-employer plan; or				
		X a single-employer plan;	a DFE	(specify)				
		_	_					
<b>B</b> This	return/report is:	the first return/report;	the fina	I return/report;				
		an amended return/report;	a short	plan year return/report (less t	han 12 months).			
<b>C</b> If the	plan is a collectively-bargaine	ed plan, check here						
D Chec	k box if filing under:	Form 5558;	automa	tic extension;	the DFVC program;			
2 0.100	K BOX II IIIII g dildor.	special extension (enter de		•				
Part	II Rasic Plan Inform	nation—enter all requested inform	· /					
	ne of plan	indition — enter an requested inform	iauon		<b>1b</b> Three-digit plan			
	•	RA LLP EMPLOYEE BENEFITS PLA	AN		number (PN) ▶	520		
					1c Effective date of pla	an		
					01/01/2004			
	i sponsor's name and address ress should include room or s	s (employer, if for a single-employer	plan)		<b>2b</b> Employer Identifica Number (EIN)	ition		
`	SON BROWN ARGIZ & FARE	,			01-0720052			
Morardo					<b>2c</b> Sponsor's telephone			
					number			
1001 BR	ICKELL BAY DRIVE	1001 BRI	ICKELL BAY DRIVE		305-373-5500 <b>2d</b> Business code (see			
9TH FLC MIAMI, F			9TH FLOOR MIAMI, FL 33131			Э		
IVII/AIVII, I	L 33 13 1	WIIAWII, F	MIAMI, I E 33131					
0	A			d				
	•	complete filing of this return/repo				dulas		
	. , ,	enalties set forth in the instructions, as the electronic version of this retur			. , ,			
SIGN	Filed with authorized/valid ele	ectronic signature.	07/29/2010	MANUEL RODRIGUEZ J	R			
HERE	Signature of plan adminis	trator	Date	Enter name of individual s	signing as plan administrator			
	Orginature or plant autilinis	liator	Date	Line name of mulvidual s	signing as plan auministrator			
SIGN								
HERE	Signature of ampleyer/pla	n enoncor	Data	Enter name of individual a	cigning as ampleyor or plan an	oncor		
	Signature of employer/pla	iii spoiisor	Date	Enter name of individual s	signing as employer or plan sp	UHSUI		
SIGN								
HEDE			I					

Date

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2009)	Pag	e <b>2</b>		
	Plan administrator's name and address (if same as plan sponsor, enter "Sam	ne")			Iministrator's EIN
9TI	1 BRICKELL BAY DRIVE I FLOOR MI, FL 33131			nu	Iministrator's telephone umber 5-373-5500
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for th	nis plan, enter the name, EIN	N and	4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year			5	205
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6	<b>b, 6c,</b> and <b>6d</b> ).		
а	Active participants			6a	215
b	Retired or separated participants receiving benefits			6b	C
С	Other retired or separated participants entitled to future benefits			6с	C
d	Subtotal. Add lines 6a, 6b, and 6c			6d	215
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits		6e	
f	Total. Add lines 6d and 6e.			6f	215
g	Number of participants with account balances as of the end of the plan year complete this item)			6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer p	lans complete this item)	7	
	If the plan provides pension benefits, enter the applicable pension feature could be the plan provides welfare benefits, enter the applicable welfare feature code:  4A 4B 4D 4L				
9a 10	Plan funding arrangement (check all that apply)  (1)	(1) (2) (3) (4)	fit arrangement (check all the X Insurance Code section 412(e)(3) Trust General assets of the sere indicated, enter the num	insurand	ce contracts

**b** General Schedules

(1)

(2)

(3)

(4)

(5)

(6)

**H** (Financial Information)

11 A (Insurance Information)

I (Financial Information – Small Plan)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

C (Service Provider Information)

a Pension Schedules

(1)

(2)

(3)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

r ension benefit duaranty of	прогашоп	pursuant to ERISA section 103(a)(2).			orm is Open to Public Inspection			
For calendar plan year 20	For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan MORRISON BROWN AR	.GIZ & FARRA	LLP EMPLOYEE BENEFITS PLA	NI .	e-digit number (PN)	520			
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number (EIN 01-0720052								
on a separat		ning Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca		RIDA						
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year			
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To			
59-2015694	98167	91046	234	10/01/2009	12/31/2009			
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	I commissions paid. List in item 3	3 the agents, brokers, and	d other persons in			
(a) Total	amount of con	nmissions paid	<b>(b)</b> To	otal amount of fees paid				
		11519			0			
3 Persons receiving com	missions and	fees. (Complete as many entries a	as needed to report all persons)					
• 1 crooms receiving com				sions or fees were naid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  AON CONSULTING INC.  1001 BRICKELL BAY DRIVE 10TH FLOOR MIAMI, FL 33131								
(b) Amount of sales ar	ad base	Fees	s and other commissions paid					
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code			
	11519	0	, ,		3			
	(a) Name	and address of the agent broker of	or other person to whom commiss	sions or fees were naid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount	(d) Purpos	(d) Purpose				

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
	I					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai				
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were pen	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

age	4
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Schedule A	(Form	5500)	2000
Scriedule A	(FOIII)	ววบบ	1 2009

Pá	Welfare Benefit Contract Information If more than one contract covers the same grant information may be combined for reporting pothe entire group of such individual contracts of the same grant information may be combined for reporting potheronal formation.	roup of employees of the urposes if such contracts	are experienc	e-rated as a unit. Who	ere contracts	
8	Benefit and contract type (check all applicable boxes)					
	a X Health (other than dental or vision)	<b>b</b> Dental	С	Vision	(	Life insurance
	e Temporary disability (accident and sickness)	f Long-term disabi	lity <b>g</b>	Supplemental unemp	oloyment <b>i</b>	Prescription drug
	i Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶			•		
9	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)		383967	
	(2) Increase (decrease) in amount due but unpaid				0	
	(3) Increase (decrease) in unearned premium res		_ ;_;		0	
	(4) Earned ((1) + (2) - (3))				9a(4)	383967
	<b>b</b> Benefit charges (1) Claims paid				318693	
	(2) Increase (decrease) in claim reserves				0	
	(3) Incurred claims (add (1) and (2))				9b(3)	318693
	(4) Claims charged				9b(4)	318693
	C Remainder of premium: (1) Retention charges (c	on an accrual basis)				
	(A) Commissions		. 9c(1)(A)		11519	
	(B) Administrative service or other fees				0	
	(C) Other specific acquisition costs		. 9c(1)(C)		0	
	(D) Other expenses				27262	
	(E) Taxes				2304	
	(F) Charges for risks or other contingencies.				24190	
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	65275
	(2) Dividends or retroactive rate refunds. (These	e amounts were 📗 paid i	n cash, or 📗 d	credited.)	9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1	) Amount held to provide	e benefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
	<b>e</b> Dividends or retroactive rate refunds due. (Do n	ot include amount entere	ed in <b>c(2)</b> .)		9e	
10	Nonexperience-rated contracts:					
	<b>a</b> Total premiums or subscription charges paid to c				10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount						
	Specify nature of costs •					

Part IV	Provision of Information			
11 Did th	ne insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	This Form is Open to Public Inspection	
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan MORRISON BROWN AR	GIZ & FARRA	LLP EMPLOYEE BENEFITS PLA	В	Three-digit plan number (P	N) <b>•</b>	520	
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number (E 01-0720052					`		
on a separat		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		CE COMPANY, INC.			D. II		
(b) EIN	(c) NAIC code	(d) Contract or identification number	<ul> <li>(e) Approximate numbe persons covered at end policy or contract yea</li> </ul>	of	From	(g) To	
59-2876465	76031	25-Y0097	138	10/01/20	009	12/31/2009	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in	item 3 the agents	s, brokers, and	other persons in	
	amount of com	missions paid		(b) Total amount	of fees paid		
(4) 10101		0		(2) : 0:0: 0:::0	o. 1000 pa.u	0	
3 Persons receiving com	missions and f	ees. (Complete as many entries a	s needed to report all person	ons).			
	(a) Name a	and address of the agent, broker, o	or other person to whom cor	mmissions or fees	s were paid		
(b) Amount of sales ar	nd base	Fees	and other commissions pa	id			
commissions pa	id	(c) Amount	(d) P	urpose		(e) Organization code	
	(a) Name a	and address of the agent, broker, o	or other person to whom cor	mmissions or fees	were paid		
	(-)	g,					
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	( <b>d)</b> P	urpose		(e) Organization code	

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
	I					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai				
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were pen	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Schedule A (Form 5500) 2009	Page <b>4</b>	
information may be combined for reporting purpos	of employees of the same employer(s) or members of the same employee organization(ses if such contracts are experience-rated as a unit. Where contracts cover individual eneach carrier may be treated as a unit for purposes of this report.	

X No

Yes

Schedule A (	Form 5500	2009
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Part III

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insurance	е
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b> 🗍	Supplemental unempl	oyment	h Prescription	drug
	i İ	Stop loss (large deductible)	j HMO contract	k	PPO contract	•	I Indemnity co	-
	m [	Other (specify)	,		]			Titidot
	···· [	_ Other (specify) •						
9	Exn	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)			-	
	_	(2) Increase (decrease) in amount due but unpaid	<b>-</b>	9a(2)			1	
		(3) Increase (decrease) in unearned premium res		9a(3)			1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (or	, , , , , , , , , , , , , , , , , , ,					
		(A) Commissions	<u>-</u>	9c(1)(A)				
		(B) Administrative service or other fees	F	9c(1)(B)			4	
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			4	
		(D) Other expenses	ħ.	9c(1)(D)			4	
		(E) Taxes	<u> </u>	9c(1)(E)			4	
		(F) Charges for risks or other contingencies	F	9c(1)(F)			4	
		(G) Other retention charges	_	9c(1)(G)		0-(4)(11)		
		(H) Total retention		_	<u> </u>	9c(1)(H)		
	_1	(2) Dividends or retroactive rate refunds. (These	<b>—</b> ·		· · · · · · · · · · · · · · · · · · ·	9c(2)		
	d	Status of policyholder reserves at end of year: (1)			-	9d(1)		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves			_	9d(3)		
10	e Na	Dividends or retroactive rate refunds due. (Do no propose presented contracts:	ot include amount entered	III C(2).)		9e		
10	a	Total premiums or subscription charges paid to c	arrior		Γ	10a		14168
	b	If the carrier, service, or other organization incurr				IVa		11100
		retention of the contract or policy, other than repo				10b		
	Sı	pecify nature of costs			_			
		•						
_		V Duardalan aflut						
ra	rt I	V Provision of Information						

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				tion	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	09 or fiscal pl	an year beginning 01/01/2009	9	and e	nding 12	/31/2009	
A Name of plan MORRISON BROWN AR	GIZ & FARR	A LLP EMPLOYEE BENEFITS F	PLAN		e-digit number (PI	N) <b>•</b>	520
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number ( 01-0720052					(EIN)		
		rning Insurance Contrac  A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		ICE COMPANY, INC.					
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or o	ontract year
<b>(b)</b> EIN	code	identification number	· '	persons covered at end of policy or contract year		From	<b>(g)</b> To
59-2876465	76031	29157		73	10/01/20	009	12/31/2009
2 Insurance fee and com descending order of the		mation. Enter the total fees and t	otal commissions paid. L	ist in item 3	3 the agents,	, brokers, and	other persons in
(a) Total	amount of cor	mmissions paid		<b>(b)</b> To	otal amount	of fees paid	
		453					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke			sions or fees	were paid	
AON CONSULTING INC.		100	1 BRICKELL BAY DRIVE			,	
			TH FLOOR MI, FL 33131				
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	453	0					3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid	<u> </u>	-	
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1					
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
	I						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai					
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were pen	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>	
lover(s) or members of the sam	_

9d(3)

9e

10a

10b

X No

Yes

3055

Schedule A (Form 5500) 2009 Page <b>4</b>							
Part III Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
8 Benefit and contract type (check all applicable boxes)							
a ☐ Health (other than dental or vision) b ☒ Dental c ☐ Vision d ☐ Life insurance							
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription d	ug						
i Stop loss (large deductible) j HMO contract k PPO contract I Indemnity con	ract						
m ☐ Other (specify) ▶							
9 Experience-rated contracts:							
a Premiums: (1) Amount received							
(2) Increase (decrease) in amount due but unpaid							
(3) Increase (decrease) in unearned premium reserve							
(4) Earned ((1) + (2) - (3))							
b Benefit charges (1) Claims paid							
(2) Increase (decrease) in claim reserves							
(3) Incurred claims (add (1) and (2))							
(4) Claims charged							
C Remainder of premium: (1) Retention charges (on an accrual basis)							
(A) Commissions							
(B) Administrative service or other fees							
(C) Other specific acquisition costs							
(D) Other expenses 9c(1)(D)							
(E) Taxes							
(F) Charges for risks or other contingencies							
(G) Other retention charges							
(H) Total retention							
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)							
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement							
(2) Claim reserves							

Part IV	Provision of Information			

(3) Other reserves

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

a Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

retention of the contract or policy, other than reported in Part I, item 2 above, report amount ......

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

10 Nonexperience-rated contracts:

Specify nature of costs

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to EDICA continu 103(a)(3)					m is Open to Public Inspection		
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan MORRISON BROWN AR	GIZ & FARRA	LLP EMPLOYEE BENEFITS PL	A N I	e-digit number (PN)	520		
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number (EIN) 01-0720052							
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:							
(a) Name of insurance car AETNA, INC.	rier						
a	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
23-2229683	95088	US379203	469	10/01/2008	09/30/2009		
2 Insurance fee and communication descending order of the		nation. Enter the total fees and total	al commissions paid. List in item 3	the agents, brokers, and o	other persons in		
(a) Total a	mount of com	nmissions paid	<b>(b)</b> To	otal amount of fees paid			
		98724			0		
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all persons).				
	(a) Name		or other person to whom commiss	ions or fees were paid			
CENTERSTONE INS FIN	ANCIAL SER	SUITI	LBJ FREEWAY E 1100 AS, TX 75244				
(b) Amount of sales ar	d base	Fee	s and other commissions paid				
commissions pai	d	(c) Amount	(d) Purpose	(e) Organization code			
	12416	0			3		
	(a) Name	and address of the agent, broker,	or other person to whom commiss	ions or fees were paid			
ADAMS BENEFIT CORPORATION  600 CORPORATE DRIVE SUITE 650 FORT LAUDERDALE, FL 33334							
<b>(b)</b> Amount of sales ar	d hase	Fee	es and other commissions paid				
commissions pai		(c) Amount	(d) Purpos	(e) Organization code			
	60753	0			3		
For Panerwork Reduction	n Act Notice	and OMB Control Numbers see	the instructions for Form 5500	Sch	edule A (Form 5500) 2009		

Schedule A (Form 5500) 2	2009	Page <b>2-</b> 1	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
CENTERSTONE INS FINANCIAL SE	R 4851 I SUITE	LBJ FREEWAY E 1100 AS, TX 75244	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
25555	0		3
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	·
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization code
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

Fees and other commissions paid

(d) Purpose

(e) Organization

code

(c) Amount

(b) Amount of sales and base

commissions paid

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>		

9d(3)

9e

10a

10b

1522729

	Schedule A (Form 5500) 2009		F	Page <b>4</b>		
Part III	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experien	ce-rated as a unit. Who	ere contracts	
8 Bene	fit and contract type (check all applicable boxes)	)				
аX	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	d	Life insurance
e l	Temporary disability (accident and sickness)	f Long-term disabili	<u> </u>	∃ Supplemental unemp	olovment <b>h</b>	Prescription drug
: -	Stop loss (large deductible)	j HMO contract		PPO contract		
' ⊨	, , ,	nivio contract	r_	_ PPO contract		Indemnity contract
m	Other (specify)					
	rience-rated contracts:			Т		
	remiums: (1) Amount received		9a(1)			
	2) Increase (decrease) in amount due but unpai					
	3) Increase (decrease) in unearned premium re-		9a(3)		2 (0)	
	4) Earned ((1) + (2) - (3))			I	9a(4)	
	Benefit charges (1) Claims paid		:-:			
	Increase (decrease) in claim reserves					
	3) Incurred claims (add (1) and (2))				9b(3)	
	4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (	•		T		
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.					
	(G) Other retention charges					
	(H) Total retention	_			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (	) Amount held to provide	benefits afte	r retirement	9d(1)	
	(2) Claim reserves				9d(2)	

(3) Other reserves

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

a Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....

Specify	/ nature	∩f	costs	Þ
Opedin	/ IIalule	OI	COSIS	•

10 Nonexperience-rated contracts:

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to E	RISA section 103(a)(2).			Inspection
For calendar plan year 200	09 or fiscal pla	n year beginning 01/01/2009	and er	nding 12	2/31/2009	
A Name of plan  MORRISON BROWN ARGIZ & FARRA LLP EMPLOYEE BENEFITS PLAN  B Three-digit  plan number (PN)					520	
	C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number (EIN) 01-0720052					
		ning Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		DMPANY OF AMERICA				
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	<b>(g)</b> To
13-5123390	64246	00413987	185	01/01/20	009	09/30/2009
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	ll commissions paid. List in item 3	the agents	, brokers, and o	ther persons in
(a) Total a	amount of com		<b>(b)</b> To	otal amount	of fees paid	
		2932				5869
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).			
		and address of the agent, broker,		ions or fees	s were paid	
ADAMS BENEFIT CORP			ORPORATE DRIVE #320 LAUDERDALE, FL 33334			
(b) Amount of sales ar	nd base	Fees	s and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code
	2925	5869 AD	DITIONAL PRODUCER COMPE	NSATION		3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
NATIONAL PLANNING CORPORATION 999 BRICKELL AVENUE SUITE 800 MIAMI, FL 33131						
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid			
commissions pai		(c) Amount	(d) Purpose	e		(e) Organization code
	8	0				3
For Donomyork Bodystia	n Act Notice	and OMP Control Numbers see	the instructions for Form FEOO		Cab	dula A /Farm 5500\ 2000

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
	I					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai				
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were pen	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>	
loyer(s) or members of the same empence-rated as a unit. Where contracts	

Schedule A	(Form	5500)	2009
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Pa	If more than one contract covers the same groinformation may be combined for reporting puthe entire group of such individual contracts w	oup of employees of the sarposes if such contracts a	re experienc	e-rated as a unit. Who	ere contract	
8	Benefit and contract type (check all applicable boxes)					
	a Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		d Life insurance
	e Temporary disability (accident and sickness)	f Long-term disability	g _	Supplemental unemp	loyment	h Prescription drug
	i Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶			•		
9	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid		9a(2)			
	(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	
	<b>b</b> Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
	<b>c</b> Remainder of premium: (1) Retention charges (or	· -	1			
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees	l l l l l l l l l l l l l l l l l l l	9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
	e Dividends or retroactive rate refunds due. (Do no	t include amount entered	in <b>c(2)</b> .)		9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to ca	arrier			10a	73658
	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount					
	Specify nature of costs •					

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to Ef	RISA section 103(a)(2).	Tills FO	Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and er	nding 12/31/2009	
A Name of plan MORRISON BROWN ARGIZ & FARRA LLP EMPLOYEE BENEFITS PLAN				e-digit number (PN)	520
C Plan sponsor's name a MORRISON BROWN AR			<b>D</b> Emplo 01-072	oyer Identification Number 20052	(EIN)
			coverage, Fees, and Computer in Parts II and III can be reported		
1 Coverage Information:					
(a) Name of insurance ca		ANCE COMPANY			
(I.) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
35-0472300	70254	000010074335	196	10/01/2008	09/30/2009
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	commissions paid. List in item 3	the agents, brokers, and	other persons in
(a) Total a	amount of comn		<b>(b)</b> To	otal amount of fees paid	
		14294			1830
3 Persons receiving com	missions and fe	es. (Complete as many entries a	is needed to report all persons).		
	(a) Name ar		or other person to whom commiss	ions or fees were paid	
ADAMS BENEFIT CORP	ORATION		DRPORATE DRIVE #650 JDERDALE, FL 33334		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa	id	(c) Amount	(d) Purpose	(e) Organization code	
	7147	915 BR	OKER BONUS		3
	(a) Name ar	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
SEITLIN BENEFITS CORPORATION  9800 NW 41ST STREET SUITE 300 DORAL, FL 33178					
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code
	7147	915 BR	OKER BONUS		3
For Bonomical Bodinetic	n Ast Notice o	nd OMB Control Numbers	the instructions for Form FEOO	Cal	adula A (Form FEOO) 2000

Schedule A (Form 5500)	Page <b>2-</b> 1		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were pen	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>	

Pa	art II	If more than one contract covers the same grainformation may be combined for reporting process.	oup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Wh	nere contracts		
8	D	the entire group of such individual contracts v	with each carrier may be	treated as a u	init for purposes of this	s report.		
0	г	efit and contract type (check all applicable boxes)	ь П <b></b>		1		-1 T	
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disabili	ity <b>g</b>	Supplemental unem	ployment l	h Prescription drug	
	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	:t
	m	Other (specify)						
9	Ехре	erience-rated contracts:						
	a I	Premiums: (1) Amount received		. 9a(1)				
		(2) Increase (decrease) in amount due but unpaid	t	. 9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	. 9a(3)				
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		. 9b(1)				
		(2) Increase (decrease) in claim reserves		. 9b(2)				
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies.		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		-
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n				9e		
10	No	nexperience-rated contracts:				•		
		Total premiums or subscription charges paid to d	arrier			. 10a		71474
	-	If the carrier, service, or other organization incur						
		retention of the contract or policy, other than repo	orted in Part I, item 2 abo	ve, report am	ount	10b		
	Sp	pecify nature of costs						
	Sp	eciry nature of costs						

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	11113 1 011	m is Open to Public Inspection		
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and er		•		
A Name of plan MORRISON BROWN AR	GIZ & FARRA I	LP EMPLOYEE BENEFITS PLA	N	e-digit number (PN)	520		
C Plan sponsor's name a MORRISON BROWN AR			<b>D</b> Emplo 01-072	yer Identification Number ( 20052	EIN)		
on a separat			overage, Fees, and Comi unit in Parts II and III can be repo				
1 Coverage Information:							
(a) Name of insurance ca		NCE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
35-0472300	70254	000010094645	215	10/01/2008	09/30/2009		
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
		7292			2736		
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons).				
	• • •	•	or other person to whom commiss	ions or fees were paid			
ADAMS BENEFIT CORP	ORATION		DRPORATE DRIVE #650 UDERDALE, FL 33334				
(b) Amount of sales a	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpose	(e) Organization code			
	3646	1368 BR	OKER BONUS		3		
	(a) Name ar	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid			
SEITLIN BENEFITS COR	RPORATION	SUITE	IW 41ST STREET 300 _, FL 33178				
(b) Amount of sales a	ad basa	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpose	9	(e) Organization code		
	3646		OKER BONUS		3		
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Sch	edule A (Form 5500) 2009		

Schedule A (Form 5500)	Page <b>2-</b> 1		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>	
nployer(s) or members of the same en prience-rated as a unit. Where contracts as a unit for purposes of this report.	
C Vision	<b>d</b> X Life insurar
<b>g</b> Supplemental unemployment	<b>h</b> Prescription
<b>k</b> PPO contract	I Indemnity of

Pá	art II	Welfare Benefit Contract Informati	ion				
		If more than one contract covers the same gro information may be combined for reporting pu					
		the entire group of such individual contracts w					to cover marviadar employees,
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabil	lity g	Supplemental unemp	oloyment	h Prescription drug
	ιİ	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	= ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	DISMEMBERMENT		]		
	••••	Totaler (specify)					
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	I	9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entere	ed in <b>c(2)</b> .)		9e	
10	) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	36458
	b	If the carrier, service, or other organization incurre					
		retention of the contract or policy, other than repo	orted in Part I, item 2 abo	ove, report am	ount	10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Specify nature of costs **\rightarrow** 

Schedule A (Form 5500) 2009

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

n					m is Open to Public Inspection		
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/200	9	and er	iding 12	/31/2009	
A Name of plan MORRISON BROWN AR	GIZ & FARR/	A LLP EMPLOYEE BENEFITS F	PLAN	B Three plan	e-digit number (Pl	N) •	520
C Plan sponsor's name a MORRISON BROWN AR				<b>D</b> Employ 01-072		cation Number (	EIN)
		rning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	E COMPANY		(e) Approximate n	umber of		Policy or co	ontract vear
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	it end of	(f)	From	<b>(g)</b> To
93-0242990	69019	144916	policy or contract	15	01/01/20		10/31/2009
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
2 Damana na shirina ann	::	4469					0
3 Persons receiving com		fees. (Complete as many entrie			ana ar faar	wore noid	
SEITLIN BENEFITS COR		SU	00 NW 4ST STREET ITE 300 AMI, FL 33178	III COIIIIIISSI	ons or rees	s were paid	
(b) Amount of sales ar	nd book	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	)		(e) Organization code
	4469	0					3
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
	(a) Name	and address of the agent, broke	or, or outer person to who	111 001111111001	0110 01 1000	were paid	
(b) Amount of sales ar		F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	)		(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1					
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
	I						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai					
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
( <b>-)</b>							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Pag	е	4

Schedule A (I	Form 550	0) 2009
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Pa	rt II	Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting purpo the entire group of such individual contracts with	o of employee oses if such co	ontracts are	experienc	ce-rated as a unit. Whe	ere contracts	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) b	Dental		С	Vision	(	d X Life insurance
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term	n disability	g	Supplemental unemp	loyment l	h Prescription drug
	i	Stop loss (large deductible)	HMO conf	tract	k	PPO contract		I Indemnity contract
	m	Other (specify)	_		_	•		
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received			9a(1)		29795	
		(2) Increase (decrease) in amount due but unpaid			9a(2)		0	
		(3) Increase (decrease) in unearned premium reserv	e		9a(3)		0	
		(4) Earned ((1) + (2) - (3))					9a(4)	29795
	b	Benefit charges (1) Claims paid			9b(1)		0	
		(2) Increase (decrease) in claim reserves			9b(2)		227	
		(3) Incurred claims (add (1) and (2))					9b(3)	227
		(4) Claims charged					9b(4)	227
	С	Remainder of premium: (1) Retention charges (on a	n accrual bas	is)				
		(A) Commissions		90	:(1)(A)		4469	
		(B) Administrative service or other fees		90	:(1)(B)		0	
		(C) Other specific acquisition costs		90	:(1)(C)		15	
		(D) Other expenses		90	:(1)(D)		2703	
		(E) Taxes		90	:(1)(E)		521	
		(F) Charges for risks or other contingencies		_	:(1)(F)		2084	
		(G) Other retention charges		90	:(1)(G)		19776	
		(H) Total retention					9c(1)(H)	29568
		(2) Dividends or retroactive rate refunds. (These am	nounts were	paid in cas	sh, or	credited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1) Ar	mount held to	provide ben	efits after	retirement	9d(1)	0
		(2) Claim reserves		•			9d(2)	7087
		(3) Other reserves					9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do not in					9e	0
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carri	er				10a	
	b	If the carrier, service, or other organization incurred	any specific c	osts in conn	ection wit	h the acquisition or		
		retention of the contract or policy, other than reporte	d in Part I, ite	m 2 above, ı	eport am	ount	10b	
	Sp	pecify nature of costs						

Part	IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Fo	rm is Open to Public Inspection				
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009						2/31/2009			
A Name of plan MORRISON BROWN ARGIZ & FARRA LLP EMPLOYEE BENEFITS PLAN			PLAN		e-digit number (Pl	N) <b>•</b>	520		
C Plan sponsor's name a MORRISON BROWN AR				<b>D</b> Emplo	-	cation Number	(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		PANY							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a			Policy or c	ontract year		
(b) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To		
93-0242990	69019	144916	204		04/01/20	008	12/31/2008		
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in		
(a) Total a	amount of cor	nmissions paid		<b>(b)</b> To	otal amount	of fees paid			
		4539					0		
3 Persons receiving com		fees. (Complete as many entrie							
SEITLIN BENEFITS COR		and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
SEITLIN BENEFITS COR	RECKATION	SU	ITE 200 AMI, FL 33178						
		IVIIA	AWII, F L 33 170						
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code		
	4539	0					3		
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
	`,'	<u> </u>	· .			•			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpose			(e) Organization code		

Schedule A (Form 5500)	2009	Page <b>2-</b> 1					
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
	I						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai					
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
( <b>-)</b>							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Ρ	ag	е	4
г	ay	C	_

Schedule A (I	Form 550	0) 2009
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Pa	rt I	Welfare Benefit Contract Information If more than one contract covers the same ground information may be combined for reporting put the entire group of such individual contracts with the such as the such individual contracts with the such as the	up of employee poses if such co	ontracts are exper	ieńc	e-rated as a unit. Whe	ere contracts	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental		С	Vision	(	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term	n disability	g 🗌	Supplemental unemp	loyment I	n Prescription drug
	i	Stop loss (large deductible)	j HMO cont	tract	k 🗌	PPO contract		I Indemnity contract
	m	Other (specify)	_					_
	L							
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)			25422	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			0	
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			0	
		(4) Earned ((1) + (2) - (3))					9a(4)	25422
	b	Benefit charges (1) Claims paid					0	
		(2) Increase (decrease) in claim reserves		9b(2)			6860	
		(3) Incurred claims (add (1) and (2))					9b(3)	6860
		(4) Claims charged					9b(4)	6860
	С	Remainder of premium: (1) Retention charges (on	an accrual bas	·	- 1			
		(A) Commissions			_		4539	
		(B) Administrative service or other fees			_		0	
		(C) Other specific acquisition costs					5633	
		(D) Other expenses					2395	
		(E) Taxes			- +		445	
		(F) Charges for risks or other contingencies			,		1780	
		(G) Other retention charges		9c(1)(0	3)		3770	
		(H) Total retention					9c(1)(H)	18562
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	C	credited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1)	Amount held to	provide benefits a	after	retirement	9d(1)	0
		(2) Claim reserves					9d(2)	6860
		(3) Other reserves					9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do not	t include amoun	t entered in c(2).)			9e	0
10	No	nexperience-rated contracts:				•		
	а	Total premiums or subscription charges paid to ca	rrier				10a	
	b	If the carrier, service, or other organization incurre	, ,			'	40h	
	_	retention of the contract or policy, other than repor	rted in Part I, ite	m 2 above, report	amo	ount	10b	
	Sp	pecify nature of costs						

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).					m is Open to Public Inspection				
For calendar plan year 20	09 or fiscal pla	n year beginning 01/01/2009	)	and end	ling 12/3	1/2009	·		
A Name of plan	A Name of plan MORRISON BROWN ARGIZ & FARRA LLP EMPLOYEE BENEFITS F				digit umber (PN)	<b>&gt;</b>	520		
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP  D Employer Identification Number (El 01-0720052)									
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca									
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e			•	ontract year		
(5) 2.11	code	identification number	policy or contract y		(f) F	rom	<b>(g)</b> To		
06-0838648	70815	860553G	202		01/01/2009	9	11/01/2009		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. List	in item 3 th	he agents, b	rokers, and	other persons in		
(a) Total amount of commissions paid				(b) Tota	al amount of	fees paid			
4632 1182					1182				
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all pe	rsons).					
<u> </u>		and address of the agent, broke			ns or fees w	ere paid			
SEITLIN BENEFITS		SUI	0 NW 41ST STREET TE 300 MI, FL 33178						
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid					
commissions pai		(c) Amount	(d)	(d) Purpose			(e) Organization code		
	4632	1182 <sup>[</sup>	BONUS PAID				3		
	(a) Name	and address of the agent, broke	r, or other person to whom o	commissio	ns or fees w	ere paid			
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid					
commissions pa		(c) Amount	(d)	Purpose			(e) Organization code		

Schedule A (Form 5500)	2009	Page <b>2-</b> 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Schedule A (Form 5500) 2009		Page <b>4</b>						
Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.								
and contract type (check all applicable boxes)								
lealth (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision	<b>d</b> X Life insurance					
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	<b>h</b> Prescription drug					
Stop loss (large deductible)	j HMO contract	k PPO contract	I Indemnity contract					
Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT	_						

O	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	, g∏	Supplemental unemp	loyment	<b>h</b> Prescription d	rug
	i İ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity con	tract
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
	L	_ Cariot (opcomy)						
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)		•			
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)			]	
		(D) Other expenses		9c(1)(D)			1	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.		9c(1)(F)			7	
		(G) Other retention charges	-   -   -   -   -   -   -   -   -   -	9c(1)(G)			7	
		(H) Total retention	<u> </u>			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	_			9c(2)		
	d	Status of policyholder reserves at end of year: (1				9d(1)		
	_	(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	_	Dividends or retroactive rate refunds due. (Do n				9e	+	
10	No	nexperience-rated contracts:	or morado amount onto eu	<del>\(_j</del> .)		36		
. •		Total premiums or subscription charges paid to o	earrier			10a		34699
	b	If the carrier, service, or other organization incur				104	+	2.200
	~	retention of the contract or policy, other than rep				10b		
	Sp	pecify nature of costs		•	•			

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Part III

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation  Insurance companies are required to pursuant to ERISA section 1			ERISA section 103(a)(2)				m is Open to Public Inspection
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and er	nding 12	/31/2009	
A Name of plan MORRISON BROWN AR	GIZ & FARRA	A LLP EMPLOYEE BENEFITS F	PLAN	B Three	e-digit number (Pl	N) <b>•</b>	520
C Plan sponsor's name as shown on line 2a of Form 5500.  MORRISON BROWN ARGIZ & FARRA LLP				<b>D</b> Emplo	-	ation Number (	EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car HARTFORD LIFE & ACC							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
06-0838648	70815	860553G	2	02	04/01/20	008	12/31/2008
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and o	ther persons in
(a) Total a	amount of com	nmissions paid		<b>(b)</b> To	tal amount	of fees paid	
3 Dorgona roppining com	missions and	food (Complete on many entrie		norcono)			0
3 Persons receiving com		fees. (Complete as many entrie			. ,		
SEITLIN BENEFITS	(a) Name	SU	or, or other person to who no NW 41ST STREET ITE 300 MII, FL 33178	m commiss	ions or rees	were paid	
<b>(b)</b> Amount of sales ar	nd basa	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	3776	0					3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
		•				·	
<b>(b)</b> Amount of sales ar			ees and other commissio				() 0
commissions pai	a	(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>•</b>				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Schedule A (Form 5500) 2009		Page <b>4</b>	
Welfare Benefit Contract Information from the same grant of the sa	roup of employees of the same urposes if such contracts are ex	xperience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision	<b>d</b> X Life insurance
emporary disability (accident and sickness)	f Long-term disability	<b>g</b> Supplemental unemployment	<b>h</b> Prescription drug
Stop loss (large deductible)	j HMO contract	<b>k</b> ☐ PPO contract	I Indemnity contract

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	loyment	h Prescription drug	
	i Î	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m			<u> </u>			- L	
	_							
9	Ехре	erience-rated contracts:	_					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	<u>.</u>	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	h de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges	_	9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were naid in o	cash. or 🗆 d	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1		L1		9d(1)		
	ď	(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	_	Dividends or retroactive rate refunds due. (Do no	9e					
10		nexperience-rated contracts:	ot moldde amount entered i	( <i>L</i> )./		36		
	a	Total premiums or subscription charges paid to c	earrier			10a	33	3309
	b	If the carrier, service, or other organization incurr				IVa		-500
	D	retention of the contract or policy, other than repo				10b		
	Sp	pecify nature of costs		•				

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Part III

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided. •